

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048458

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 252

FILED JAN 7 1964

VS 300
Rev. 4/59

1 0497

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARTHAGE		c. CITY OR TOWN SARGOXIE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MCCUNE BROOKS HOSP.		d. STREET ADDRESS (If Outside, give location) ROUTE # 1	
3. NAME OF DECEASED (Type or print) First EVERETT Middle ELMER Last ROBB		4. DATE OF DEATH Month 12 Day 27 Year 63	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-24-05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO SALVAGE		10b. KIND OF BUSINESS OR INDUSTRY SALVAGE	11. BIRTHPLACE (City and state or country) MILLER, Mo.
13a. FATHER'S NAME J.T. ROBB		13b. MOTHER'S MAIDEN NAME DELLA HAYES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Address MRS. MILDRED ROBB-SARGOXIE, Rt. 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed natural causes (coroner investigated) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION CARTHAGE, MISSOURI	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) Elly Clinton, Local Registrar	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-31-63	
23c. NAME OF CEMETERY OR CREMATORY PARK CEMETERY		23d. LOCATION (City, town, or county) CARTHAGE, MISSOURI	
24. FUNERAL DIRECTOR ULMER-MOSS		25. DATE RECD. BY LOCAL REG. 12-30-63	
26. REGISTRAR'S SIGNATURE Elly Clinton		22c. DATE SIGNED 12-30-63	

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin Garrett

Licensed Embalmer No. 5121
P. O. Address Carthage, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.